INDEPENDENT HEALTH'S

2024 Member Handbook

MEDISOURCE®

Independent Health®

Updated October 2023

LANGUAGE ASSISTANCE

ATTENTION: Language assistance services, free of charge, are available to you. Call 1-800-501-3439; TTY: 711.	English
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-501-3439; TTY: 711.	Spanish
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-501-3439; TTY: 711.	Chinese
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-501-3439 رقم هاتف الصم والبكم TTY: 711	Arabic
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다 1-800-501-3439; TTY: 711. 번으로 전화해 주십시오.	Korean
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-501-3439 (телетайп: TTY: 711.	Russian
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-501-3439; TTY: 711.	Italian
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-501-3439; TTY: 711.	French
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-501-3439; TTY: 711.	French Creole
אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט 1-800-501-3439 TTY: 711.	Yiddish
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-501-3439; TTY: 711.	Polish
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-501-3439; TTY: 711.	Tagalog
লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১- 1-800-501-3439; TTY: 711.	Bengali
KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-800-501-3439; TTY: 711.	Albanian
ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-800-501-3439; TTY: 711.	Greek
خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ 1-800-501-3439; TTY: 711 کال کریں	Urdu

Independent Health
Dedicated to Making a Difference

NOTICE OF NON-DISCRIMINATION

Independent Health complies with Federal civil rights laws. **Independent Health** does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Independent Health provides the following:

- Free aids and services to people with disabilities to help you communicate with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose first language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call **Independent Health** at 1-833-891-9372For TTY/TDD services, call 711.

If you believe that **Independent Health** has not given you these services or treated you differently because of race, color, national origin, age, disability, or sex, you can file a grievance with **Independent Health** by:

Mail:	511 Farber Lakes Dr, Buffalo, NY 14221
Phone:	1-833-891-9372 (for TTY/TDD services, call 711)
Fax:	716-635-3504
In person:	250 Essjay Rd, Buffalo, NY 14221
Email:	memberservice@servicing.independenthealth.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by:

Web:	Office for Civil Rights Complaint Portal at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*
Mail:	U.S. Department of Health and Human Services 200 Independence Avenue SW., Room 509F, HHH Building Washington, DC 20201 Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html
Phone:	1-800-368-1019 (TTY/TDD 800-537-7697)

HERE'S WHERE TO FIND INFORMATION YOU WANT

Welcome to Independent Health's MediSource

Medicaid Managed Care Program

We are glad that you enrolled in MediSource. This handbook will be your guide to the full range of health care services available to you. We want to be sure you get off to a good start as a new member. In order to get to know you better, we will get in touch with you in the next two or three weeks. You can ask us any questions you have or get help making appointments. If you need to speak with us before we call on you, however, just call us at 1-833-891-9372.

HOW MANAGED CARE PLANS WORK

INDEPENDENT HEALTH, OUR PROVIDERS, AND YOU

You may have heard about the changes in health care. Many consumers get their health benefits through managed care, which provides a central home for your care. If you were getting behavioral health services using your Medicaid card, now those services may be available through MediSource.

Independent Health has a contract with the State Department of Health to meet the health care needs of people with Medicaid. In turn, we choose a group of health care providers to help us meet your needs. These doctors and specialists, hospitals, labs, and other health care facilities make up our provider network. You will find a list in our provider directory. If you do not have a provider directory, call 1-833-891-9372 to get a copy or visit our website at independenthealth.com.

When you join MediSource, one of our providers will take care of you. Most of the time that person will be your Primary Care Provider (PCP). If you need to have a test, see a specialist, or go into the hospital, your PCP will arrange it.

Your PCP is available to you every day – day and night. If you need to speak to him or her after hours or weekends, leave a message and how you can be reached. Your PCP will get back to you as soon as possible. Even though your PCP is your main source for health care, in some cases, you can self-refer to certain doctors for some services. See page 10 for details.

You may be restricted to certain plan providers if you have been identified as a restricted recipient. Below are examples of why you may be restricted:

- You're getting care from several doctors for the same problem.
- You're getting medical care more often than needed.

- You're using prescription medicine in a way that may be dangerous to your health.
- You're allowing someone other than yourself to use your plan ID card.

CONFIDENTIALITY

We respect your right to privacy. Independent Health recognizes the trust needed between you, your family, your doctors, and other care providers. Independent Health will never give out your medical or behavioral health history without your written approval. The only persons that will have your clinical information will be Independent Health, your Primary Care Provider (PCP), and other providers who give you care, and you authorized representative. Referrals to such providers will always be discussed with you in advance by your PCP or your Health Home Care Manager if you have one. Independent Health's staff has been trained in keeping strict member confidentiality.

HOW TO USE THIS HANDBOOK

This handbook will help you when you join a managed care plan. It will tell you how your new health care system will work and how you can get the most from Independent Health's MediSource plan. This handbook is your guide to health and wellness services. It tells you the steps to take to make the plan work for you.

The first several pages will tell you what you need to know right away. The rest of the handbook can wait until you need it. Use it for reference or check it out a bit at a time.

When you have a question, check this handbook, or call our Member Services Department at 1-833-891-9372. You can also call the managed care staff at your local Department of Social Services.

Help from Member Services

There is someone to help you at Member Services:

Call 1-833-891-9372 from Monday – Friday, 8 a.m. – 8 p.m.

If you need help at other times, call us at 1-800-418-9231. TTY users may call 711.

You can call Member Services to get help **anytime you have a question**. You may call us to choose or change your Primary Care Provider (PCP), ask about benefits and services, get help with referrals, replace a lost ID card, report the birth of a new baby, or ask about any change that might affect you or your family's benefits.

If you are or become pregnant, your child will become part of MediSource on the day he or she is born. This will happen unless your newborn child is in a group that cannot join managed care. You should call us and your LDSS right away if you become pregnant and let us help you choose a doctor for your **newborn baby** before he or she is born.

We offer free sessions to explain our health plan and how we can best help you. It's a great time for you to ask questions and meet other members. If you'd like to come to one of the sessions, call us to find a time and place that is best for you.

If you do not speak English, we can help. We want you to know how to use your health care plan, no matter what language you speak. Just call us and we will find a way to talk to you in your own language. We have a group of people who can help. We will also help you find a PCP who can serve you in your language.

For people with disabilities: If you use a wheelchair, are blind or have trouble hearing or understanding, call us if you need extra help. We can tell you if a particular provider's office is wheelchair-accessible or is equipped with special communications devices. Also, we have services like:

- TTY machine (Independent Health's TTY phone number is 711.
- Information in large print.
- Case management.
- Help in making or getting to appointments.
- Names and addresses of providers who specialize in your disability.

If you or your child are getting care in your home now, your nurse or attendant may not know you have joined our plan. Call us right away to make sure your home care does not stop unexpectedly.

YOUR HEALTH PLAN ID CARD

After you enroll, we will send you a welcome letter. Your MediSource ID card should arrive within 14 days after your enrollment date. Your card has your Primary Care Provider's (PCP) name and phone number on it. It will also have your client identification number (CIN). If anything is wrong on your MediSource ID card, call us right away. Your ID card does not show that you have Medicaid or that MediSource is a special type of health plan.

Carry your ID card at all times and show it each time you go for care. If you need care before the card comes, your welcome letter is proof that you are a member. You should keep your Medicaid Benefit card. You will need the card to get services that MediSource does not cover.

PART I – First Things You Should Know

HOW TO CHOOSE YOUR PRIMARY CARE PROVIDER (PCP)

You may have already picked your Primary Care Provider (PCP). **If you have not chosen a PCP, you should do so right away.** If you do not choose a doctor within 30 days, we will choose one for you. Member Services can check to see if you already have a PCP or help you choose a PCP. **You may also be able to choose a PCP at your behavioral health clinic.**

Each family member can have a different PCP, or you can choose one PCP to take care of the whole family. A pediatrician treats children. Family practice doctors treat the whole family. Internal medicine doctors treat adults. Member Services can help you choose a PCP. Member Services, at 1-833-891-9372, can check to see if you already have a PCP or help you choose a PCP.

With this handbook, you should have a provider directory. This is a list of all the doctors, clinics, hospitals, labs, and others who work with Independent Health's MediSource plan. It lists the address, phone, and special training of the doctors. The provider directory will show which doctors and providers are taking new patients. You should call their offices to make sure that they are taking new patients at the time you choose a PCP. You can also get a list of providers on our website at independenthealth.com.

You may want to find a doctor that:

- You have seen before,
- Understands your health problems,
- Is taking new patients,
- Can serve you in your language, or
- Is easy to get to.

Women can also choose one of our OB/GYN doctors to deal with women's health care. Women do not need a PCP referral to see a plan OB/GYN doctor. They can have routine checkups, follow-up care if needed, and regular care during pregnancy.

We also contract with Federally Qualified Health Centers (FQHC). All FQHCs give primary and specialty care. Some consumers want to get their care from an FQHC because the centers have a long history in the neighborhood. Maybe you want to try them because they are easy to get to. You should know that you have a choice. You can choose any one of the providers listed in

our directory. Or you can sign up with a PCP at one of the FQHCs that we work with, listed below. Just call Member Services at 1-833-891-9372 for help.

Federally Qualified Health Centers:

Community Health Center of Buffalo, Inc.
34 Benwood Avenue
Buffalo, NY 14214
(716)-986-9199

Community Health Center of Niagara
501 10th Street
Niagara Falls, NY 14301
(716)278-4418
Monday – Thursday 9 a.m. – 6 p.m., Friday 8 a.m. – 5 p.m.

Jericho Road Community Health Center
1609 Genesee Street
Buffalo, NY 14211-1616
(716) 881-6191

Jericho Road Community Health Center
184 Barton Street
Buffalo, NY 14213
(716)881-6191

Northwest Buffalo Community Health Center
155 Lawn Avenue at Military Road
Buffalo, NY 14207
(716)875-2904

HEALTH HOME CARE MANAGEMENT

Independent Health wants to meet all of your health needs. If you have multiple health issues, you may benefit from Health Home Care Management to help coordinate all of your health services.

A Health Home Care Manager can:

- Work with your PCP and other providers to coordinate all of your health care.
- Work with the people you trust, like family members or friends, to help you plan and get your care.
- Help with appointments with your PCP and other providers; and
- Help manage ongoing medical issues like diabetes, asthma, and high blood pressure.

To learn more about Health Homes, contact Member Services at 1-833-891-9372.

In almost all cases, your doctors will be MediSource providers. There are four instances when you can still see **another provider that you had before you joined MediSource**. In these cases, your provider must agree to work with MediSource. You can continue to see your doctor if:

- You are more than 3 months pregnant when you join Independent Health, and you are getting prenatal care. In that case, you can keep your provider until after your delivery, through postpartum care.
- At the time you join Independent Health, you have a life threatening disease or condition that gets worse with time. In that case, you can ask to keep your provider for up to 60 days.
- At the time you join Independent Health, regular Medicaid paid for your home care, and you need to keep getting that care for at least 120 days. In that case, you can keep your same home care agency, nurse or attendant, and the same amount of home care, for at least 90 days.
- At the time you join Independent Health, you are being treated for a Behavioral Health condition. In most cases, you can still go to the same provider. Some people may have to choose a provider that works with the health plan. Be sure to talk to your provider about this change. Independent Health will work with you and your provider to make sure you keep getting the care you need.

Independent Health must tell you about any changes to your home care before the changes take effect.

If you have a long-lasting illness, like HIV/AIDS or other long term health problems, you may be able to **choose a specialist to act as your PCP.** Your physician, PCP and medical director from Independent Health will determine if you will require specialized medical care for a prolonged period of time and if this arrangement is best for you.

Requests for approval must be made in writing by your provider and submitted to Independent Health's Office of the Medical Director, 511 Farber Lakes Drive, Buffalo, NY 14221.

Please note that the HIV/AIDS specialists in our area do function as PCPs, which means that you can easily list one of them as your PCP. Please call Member Services for help.

If you need to, you can **change your PCP** in the first 30 days after your first appointment with your PCP. You have the right to change your PCP at any time by calling Member Services. This change will occur as long as the physician is accepting new patients. Call Member Services at 1-833-891-9372 and we can assist in making the necessary changes for you that day. You can also change your OB/GYN or a specialist to whom your PCP referred you. Please remember, not all PCPs are able to take new patients.

If your **provider leaves MediSource**, we will tell you within 15 days from when we know about this. If you wish, you may be able to see that provider if you are more than three months pregnant or if you are receiving ongoing treatment for a condition. If you are pregnant, you may continue to see your doctor for up to 60 days after delivery. If you are seeing a doctor regularly for an ongoing condition, you may continue your present course of treatment for up to 90 days. Your doctor must agree to work with Independent Health's MediSource during this time.

If any of these conditions apply to you, check with your PCP or call Member Services at 1-833-891-9372.

HOW TO GET REGULAR HEALTH CARE

Regular health care means exams, regular checkups, shots, or other treatments to keep you well, give you advice when you need it, and refer you to the hospital or specialists when needed. It means you and your PCP working together to keep you well or to see that you get the care you need.

Day or night, your PCP is only a phone call away. Be sure to call him or her whenever you have a medical question or concern. If you call after hours or weekends, leave a message and where or how you can be reached. Your PCP will call you back as quickly as possible. Remember, your PCP knows you and knows how the health plan works.

Your care must be **medically necessary**. The services you get must be needed to:

- Prevent or diagnose and correct what could cause more suffering.
- Deal with a danger to your life.
- Deal with a problem that could cause illness.
- Deal with something that could limit your normal activities.

Your PCP will take care of most of your health care needs, but you must have an appointment to see your PCP. If ever you can't keep an appointment, call to let your PCP know.

As soon as you choose a PCP, call to make a first appointment. If you can, prepare for your first appointment. Your PCP will need to know as much about your medical history as you can tell him or her. Make a list of your medical background, any problems you have now, any medications you are taking, and the questions you want to ask your PCP. In most cases, your first visit should be within three months of your joining the plan.

If you need care before your first appointment, call your PCP's office to explain your concern. He or she will give you an earlier appointment. You should still keep the first appointment to discuss your medical history and ask questions.

Use the following list as **an appointment guide for our limits on how long you may have to wait after your request for an appointment**:

- Adult baseline and routine physicals: within 12 weeks.
- Urgent care: within 24 hours.
- Non-urgent sick visits: within 3 days.
- Routine, preventive care: within 4 weeks.
- First prenatal visit: within 3 weeks during first trimester (2 weeks during second trimester, 1 week during third trimester).
- First newborn visit: within 2 weeks of hospital discharge.
- First family planning visit: within 2 weeks.
- Follow-up visit after mental health/substance abuse emergency room or inpatient visit: 5 days.
- Non-urgent mental health or substance abuse visit: 1 week.

HOW TO GET SPECIALTY CARE AND REFERRALS

- If you need care that your PCP cannot give, he or she will REFER you to a specialist who can. If your PCP refers you to another doctor, we will pay for your care. Most of these specialists are Independent Health providers. Talk with your PCP to be sure you know how referrals work.
- If you think a specialist does not meet your needs, talk to your PCP. Your PCP can help you if you need to see a different specialist.
- There are some treatments and services that your PCP must ask Independent Health to approve before you can get them. Your PCP will be able to tell you what they are.
- If you are having trouble getting a referral you think you need, contact Member Services at 1-833-891-9372, TTY/TDD users call, 711.
- If we do not have a specialist in our provider network who can give you the care you need, we will get you the care you need from a specialist outside our plan. This is called an **out-of-network referral**. Your PCP or plan provider must ask Independent Health for approval before you can get an out-of-network referral. If your PCP or plan provider refers you to a provider who is not in our network, you are not responsible for any of the costs except any co-payments as described in this handbook.

- If you or your doctor requested prior authorization to receive health care services from a health care provider who is not part of Independent Health's network of participating providers and we do not authorize your request, the letter you receive may be called an "out-of-network denial." If you would like to appeal an out-of-network denial, there are a few special rules you need to follow. First, as part of your appeal, a physician (who is a licensed, board-certified, or board-eligible physician qualified to practice in the specialty area appropriate to treat the member for the specific service sought) will be required to certify that the out-of-network health service is materially different from the alternate recommended in-network service proposed by Independent Health. Furthermore, you or your designee will also be required to submit two documents from the available medical and scientific evidence, which indicate that the out-of-network service is likely to be more clinically beneficial than the alternate in-network treatment proposed by Independent Health and the adverse risk of the out-of-network health service would likely not be substantially increased over the alternate in-network treatment proposed by Independent Health.
    - Sometimes, we may not approve an out-of-network referral for a specific treatment because you asked for care that is not very different from what you can get from Independent Health's provider. You can ask us to check if your out-of-network referral for the treatment you want is medically needed. You will need to ask for a Plan Appeal. See Page 28 of this attachment to find out how.
- If you need to see a specialist for ongoing care, your PCP may be able to refer you for a specified number of visits or length of time (**a standing referral**). If you have a standing referral, you will not need a new referral for each time you need care.
- If you have a long term disease or disabling illness that gets worse over time, your PCP may be able to arrange for:
    - Your specialist to act as your PCP; or
    - A referral to a specialty care center that deals with the treatment of your illness.

You can also call Member Services for help getting access to a specialty care center.

GET THESE SERVICES FROM MEDISOURCE *WITHOUT* A REFERRAL

WOMEN'S HEALTH CARE

You do not need a referral from your PCP to see one of our providers if:

- You are pregnant.
- You need OB/GYN services.
- You need family planning services.
- You want to see a mid-wife.
- You need to have a breast or pelvic exam.

FAMILY PLANNING

You can get the following family planning services: advice about birth control, birth control prescriptions, male and female condoms, pregnancy tests, sterilization, or an abortion. During your visits for these things, you can also get tests for sexually transmitted infections, a breast cancer exam, or a pelvic exam.

You do not need a referral from your PCP to get these services. In fact, you can choose where to get these services. You can use your MediSource ID card to see one of our family planning providers. Check Independent Health's MediSource provider directory or call Member Services for help in finding a provider.

Or, you can use your Medicaid card if you want to go to a doctor or clinic outside our plan. Ask your PCP or call Member Services at 1-833-891-9372 to ask for a list of places to go to get these services. You can also call the New York State Growing Up Healthy Hotline at 1-800-522-5006 for the names of family planning providers near you.

HIV AND STI SCREENING

Everyone should know their HIV status. HIV and sexually transmitted infection screenings are part of your regular health care.

You can get an HIV or STI test any time you have an office or clinic visit.

You can get an HIV or STI test any time you have family planning services. You do not need a referral from your Primary Care Provider (PCP). Just make an appointment with any family planning provider. If you want an HIV or STI test, but **not as part of a family planning service**, your PCP can provide or arrange it for you.

Or, if you'd rather not see one of our MediSource providers, you can use your Medicaid card to see a family planning provider outside MediSource. For help in finding either a MediSource provider or a Medicaid provider for family planning services, call Member Services at 1-833-891-9372.

Everyone should talk to their doctor about having an HIV test. To get free HIV testing or testing where your name isn't given, call 1-800-541-AIDS (English) or 1-800-233-SIDA (Spanish).

Some tests are "rapid tests", and the results are ready while you wait. The provider who gives you the test will explain the results and arrange for follow up care if needed. You will also learn how to protect your partner. If your test is negative, we can help you learn to stay that way.

EYE CARE

The covered benefits include the needed services of an ophthalmologist, optometrist, and an ophthalmic dispenser, and include an eye exam and pair of eyeglasses, if needed. Generally, you can get these once every two years, or more often if medically needed. Enrollees diagnosed with diabetes may self-refer for a dilated eye (retinal) examination once in any 12-month period. You just choose one of our participating providers.

New eyeglasses, with Medicaid approved frames, are usually provided once every two years. New lenses may be ordered more often, if, for example, your vision changes more than one-half diopter. If you break your glasses, they can be repaired. Lost eyeglasses, or broken eyeglasses that can't be fixed, will be replaced with the same prescription and style of frames. If you need to see an eye specialist for care of an eye disease or defect, your PCP will refer you.

BEHAVIORAL HEALTH – (MENTAL HEALTH AND SUBSTANCE USE)

We want to help you get the mental health and drug or alcohol use services that you may need. If at any time you think you need help with mental health or substance use, you can see behavioral health providers in our network to see what services you may need. This includes services like clinic and detox services. You do not need a referral from your PCP.

SMOKING CESSATION

You can get medication, supplies and counseling if you want help to quit smoking. You do not need a referral from your PCP to get these services.

MATERNAL DEPRESSION SCREENING

If you are pregnant and think you need help with depression, you can get a screening to see what services you may need. You do not need a referral from your PCP. You can get a screening for depression during pregnancy and for up to a year after your delivery.

EMERGENCIES

You are always covered for emergencies.

An emergency means a medical or behavioral condition:

- That comes on all of a sudden, and
- Has pain or other symptoms.

An emergency would make a person with an average knowledge of health fear that someone will suffer serious harm to body parts or functions or serious disfigurement without care right away.

Examples of an emergency are:

- A heart attack or severe chest pain
- Bleeding that won't stop or a bad burn
- Broken bones
- Trouble breathing, convulsions, or loss of consciousness
- When you feel you might hurt yourself or others
- If you are pregnant and have signs like pain, bleeding, fever, or vomiting
- Drug overdose

Examples of **non-emergencies** are colds, sore throat, upset stomach, minor cuts and bruises, or sprained muscles.

Non-emergencies may also be family issues, a breakup, or wanting to use alcohol or other drugs. These may feel like an emergency, but they are not a reason to go to the emergency room.

If you have an emergency, here's what to do:

If you believe you have an **emergency**, call 911 or go to the emergency room. You do not need Independent Health's or your PCP's approval before getting emergency care, and you are not required to use our hospitals or doctors.

If you're not sure, call your PCP or Independent Health.

Tell the person you speak with what is happening. Your PCP or Member Services representative will:

- Tell you what to do at home,
- Tell you to come to the PCP's office, or
- Tell you to go to the nearest emergency room.

If you are **out of the area** when you have an emergency:

- Go to the nearest emergency room.

Remember

You do not need prior approval for emergency services.

Use the emergency room only if you have an emergency.

The emergency room should NOT be used for problems like the flu, sore throats, or ear infections.

If you have questions, call your PCP or Independent Health at 1-833-891-9372.

URGENT CARE

You may have an injury or an illness that is not an emergency but still needs prompt care.

- This could be a child with an earache who wakes up in the middle of the night and won't stop crying.
- This could be the flu or if you need stitches.
- It could be a sprained ankle, or a bad splinter you can't remove.

You can get an appointment for an urgent care visit for the same or next day. Whether you are at home or away, call your PCP any time, day or night. If you cannot reach your PCP, call us at 1-833-891-9372. Tell the person who answers what is happening. They will tell you what to do.

CARE OUTSIDE OF THE UNITED STATES

If you travel outside of the United States, you can get urgent and emergency care only in the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands and American Samoa. If you need medical care while in any other country (including Canada and Mexico), you will have to pay for it.

WE WANT TO KEEP YOU HEALTHY

Besides the regular checkups and the shots you and your family need, here are some other ways to keep you in good health:

- Classes for you and your family
- Stop-smoking classes
- Prenatal care and nutrition
- Grief/loss support
- Breast feeding and baby care
- Stress management
- Weight control
- Cholesterol control
- Diabetes counseling and self-management training
- Asthma counseling and self-management training
- Sexually Transmitted Infection (STI) testing and protecting yourself from STIs
- Domestic violence services

Call Member Services at 1-833-891-9372 or visit our website at independenthealth.com to find out more and get a list of upcoming classes.

Part 2 – Your Benefits and Plan Procedures

The rest of this handbook is for your information when you need it. It lists the covered and the non-covered services. If you have a complaint, the handbook tells you what to do. The handbook has other information you may find useful. Keep this handbook handy for when you need it.

BENEFITS

Medicaid Managed Care provides a number of services you get in addition to those you get with regular Medicaid. Independent Health will provide or arrange for most services that you will need. You can get a few services, however, without going through your PCP. These include emergency care; family planning/HIV testing and counseling; and specific self-referral services, including those you can get from within MediSource and some that you can choose to go to any Medicaid provider of the service. Please call our Member Services Department at 1-833-891-9372 if you have any questions or need help with any of the services below.

SERVICES COVERED BY MEDISOURCE

You must get these services from the providers who are in MediSource. All services must be medically or clinically necessary and provided or referred by your Primary Care Provider (PCP). Please call our Member Services Department at 1-833-891-9372 if you have any questions or need help with any of the services below.

REGULAR MEDICAL CARE

- Office visits with your PCP
- Referrals to specialists
- Eye/hearing exams

PREVENTIVE CARE

- Well-baby care
- Well-childcare
- Regular checkups
- Shots for children from birth through childhood
- Access to Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services for enrollees from birth until age 21 years
- Smoking cessation counseling
- Access to free needles and syringes

- HIV education and risk reduction

MATERNITY CARE

- Pregnancy care
- Doctors/mid-wife and hospital services
- Newborn nursery care
- Screening for depression during pregnancy and up to a year after delivery

HOME HEALTH CARE

- Must be medically needed and arranged by Independent Health.
- One medically necessary postpartum home health visit, additional visits as medically necessary for high-risk women.
- At least 2 visits to high-risk infants (newborns).
- Other home health care visits as needed and ordered by your PCP/specialist

PERSONAL CARE/HOME ATTENDANT AND

CONSUMER DIRECTED PERSONAL ASSISTANCE SERVICES (CDPAS)

- Must be medically needed and arranged by Independent Health.
- Personal Care/Home Attendant – Help with bathing, dressing, and feeding, and help with preparing meals and housekeeping.
- CDPAS – Help with bathing, dressing, and feeding, help preparing meals and housekeeping, plus home health aide and nursing tasks. This is provided by an aide chosen and directed by you.

If you want more information, contact Independent Health's Member Services at 1-833-891-9372.

PERSONAL EMERGENCEY RESPONSE SYSTEM (PERS)

- This is an item you wear in case you have an emergency.
- To qualify to get this service, you must be receiving personal care/home attendant or CDPAS services.

ADULT DAY HEALTH CARE

- Must be recommended by your Primary Care Provider (PCP).
- Provides health education, nutrition, nursing, and social services; help with daily living, rehabilitative therapy, and pharmacy services; plus, referrals for dental and other specialty care.

AIDS ADULT DAY HEALTH CARE

- Must be recommended by your Primary Care Provider (PCP).
- Provides general medical and nursing care, substance use supportive services, mental health supportive services, nutritional services, plus socialization, recreational and wellness/health promotion activities.

THERAPY FOR TUBERCULOSIS (TB)

- This is help with taking your medication for TB and follow up care

HOSPICE CARE

- Hospice helps patients and their families with their special needs that come during the final stages of illness and after death.
- Must be medically needed and arranged by Independent Health.
- Provides support services and some medical services to patients who are ill and expect to live for one year or less.
- You can get these services in your home or in a hospital or nursing home.

Children under age twenty-one (21) who are getting hospice services can also get medically needed curative services and palliative care.

If you have any questions about this benefit, you can call Member Services at 1-833-891-9372.

DENTAL CARE

Independent Health believes that providing you with good dental care is important to your overall health care. We offer dental care through a contract with Liberty Dental, an expert in providing high-quality dental services. Covered services include regular and routine dental services such as preventive dental checkups, cleanings, X-rays, fillings, and other services to check for any changes or abnormalities that may require treatment and/or follow-up care for you. **You do not need a referral from your PCP to see a dentist!**

How to Get Dental Services:

- Upon enrollment into MediSource, Liberty Dental will assign a participating dentist who is closest to your home.
- You will receive a separate dental ID card with the name of your assigned dentist. Show your dental ID card to access dental benefits.
- If you have any question about your coverage or would prefer to choose a different dentist who is part of the Liberty Dental network, contact Liberty Dental directly at 1-877-550-4283. Customer Service representatives are there to help you Monday – Friday, 8 a.m. – 6 p.m. Many speak your language or have a contract with Language Line Services.
- You can also go to a dental clinic that is run by an academic dental center without a referral.

University at Buffalo

State University of New York

School of Dental Medicine 158 Squire Hall

Buffalo, NY 14214

(716) 829-2821

Liberty Dental has contracted with certain dentists in Erie County and surrounding areas who will provide dental services for Independent Health's MediSource members.

If you need to find a dentist or change your dentist, please call Liberty Dental at 1-877-550-4283 or please call Independent Health at 1-833-891-9372. Customer Service representatives are there to help you. Many speak your language or have a contract with Language Line Services.

You will receive a separate dental ID card with the name of your assigned dentist. Show your dental ID card to access dental benefits.

ORTHODONTIC CARE

Independent Health will cover braces for children up to age 21 who have a severe problem with their teeth, such as can't chew food due to severely crooked teeth, cleft palette, or cleft lip.

VISION CARE

- Services of an ophthalmologist, ophthalmic dispenser and optometrist, and coverage for contact lenses, polycarbonate lenses, artificial eyes, and or replacement of lost or destroyed glasses, including repairs, when medically necessary. Artificial eyes are covered as ordered by a MediSource provider.
- Eye exams, generally every two years, unless medically needed more often.
- Glasses (new pair of Medicaid approved frames every two years, or more often if medically needed).
- Low vision exam and vision aids ordered by your doctor.
- Specialist referrals for eye diseases or defects.
- Enrollees diagnosed with diabetes may self-refer for a dilated eye (retinal) examination once in any 12-month period.

PHARMACY

- Prescription drugs
- Over-the-counter (OTC) medicines
- Insulin and diabetic supplies
- Smoking cessation agents, including OTC products
- Drugs to treat mental illness, substance use (MAT)
- Hearing aid batteries
- Enteral formula
- Emergency contraception (six per calendar year)
- Medical and surgical supplies

A pharmacy copayment may be required for some people, for some medications and pharmacy items. There are no copays for the following members or services:

- Consumers under age 21.

- Consumers who are pregnant. Pregnant women are exempt during pregnancy and for the two months after the month in which the pregnancy ends.
- Consumers in an OMH or OPWDD Home and Community Based Services (HCBS) Waiver Program.
- Consumers in a DOH HCBS Waiver Program for Persons with Traumatic Brain Injury (TBI).
- Family planning drugs and supplies, like birth control pills and male or female condoms.
- Drugs to treat mental illness (psychotropic) and tuberculosis.
- Consumers who are residents in an adult care facility licensed by the New York State Department of Health.
- Consumers who are residents in a nursing home.
- Consumers in a Comprehensive Medicaid Case Management or Services Coordination Program.
- Consumers with incomes below 100% of the federal poverty level.
- Consumers in hospice.
- American-Indians and Alaska natives who have ever received a service from the Indian Health Service, tribal health programs, or under contract health services referral

Prescription Item	Copayment Amount
Brand name prescription drugs/Preferred brand drugs	$3.00/$1.00
Generic prescription drugs	$1.00
Over the counter drugs, such as aspirin and vitamins	$0.50

There is a copayment for each new prescription and each refill.

If you transferred plans during the calendar year, keep your receipts as proof of your copayments or you may request proof of paid copayments from your pharmacy. You will need to give a copy to your new plan.

Your maximum pharmacy co-payment (co-pay) will be $50 per quarter year. The co-pay maximum re-sets each quarter, regardless of the amount you paid last quarter.

The quarters are:

- First quarter: January 1 – March 31
- Second quarter: April 1 – June 30
- Third quarter: July 1 – September 30
- Fourth quarter: October 1 – December 31

If you are unable to pay the requested co-pay you should tell the provider. The provider cannot refuse to give you services or goods because you are unable to pay the co-pay. (Unpaid co-pays are a debt you owe the provider.)

To learn more about these services, call Member Services at 716-250-7183 or 1-833-891-9372, TTY users call: 711.

Certain medications may require that your doctor get prior authorization from us before writing your prescription. Your doctor can work with Independent Health to make sure you get the medications that you need. Learn more about prior authorization later in this handbook.

You have a choice in where you fill your prescriptions. You can go to any pharmacy that participates with Independent Health's MediSource or you can fill your prescriptions by using a mail order pharmacy. For more information on your options, please contact Member Services at 1-833-891-9372.

HOSPITAL CARE

- Inpatient care
- Outpatient care
- Lab, X-ray, other tests

EMERGENCEY CARE

- Emergency care services are procedures, treatments or services needed to evaluate or stabilize an emergency.
- After you have received emergency care, you may need other care to make sure you remain in stable condition. Depending on the need, you may be treated in the Emergency Room, in an inpatient hospital room, or in another setting. This is called Post Stabilization Services.
- For more about emergency services, see page 12.

SPECIALTY CARE

Includes the services of other practitioners, including:

- physical therapist
- occupational and speech therapists
- audiologist
- midwives
- cardiac rehabilitation
- other specialty care

To learn more about these services, call Member Services at (716) 631-8701 or 1-833-891-9372 (TTY users call 711).

RESIDENTAL HEALTH CARE FACILITY SERVICES (NURSING HOME)

Covered nursing home services include:

- Medical supervision
- 24-hour nursing care
- Assistance with daily living
- Physical therapy
- Occupational therapy
- Speech-language pathology and other services

- Short term, or rehab stay, and long term care

To get these nursing home services:

- The services must be ordered by your physician, and
- The services must be authorized by Independent Health

Rehabilitation: Independent Health covers short-term, or rehabilitation (also known as "rehab") stays, in a skilled nursing home facility.

Long-Term Placement: Independent Health covers long-term placement in a nursing home facility for members 21 years of age and older.

Eligible Veterans, Spouses of Eligible Veterans, and Gold Star Parents of Eligible Veterans: may choose to stay in a Veterans' nursing home.

Determining Your Medicaid Eligibility for Long-Term Nursing Home Services

You must apply to your Local Department of Social Services (LDSS) to have Medicaid and/or Independent Health pay for long-term nursing home services. The LDSS will review your income and assets to determine your eligibility for long-term nursing home services. The LDSS will let you know about any costs you may have to contribute toward your long-term nursing home care.

Questions

If you have any questions about these benefits, call our Member Services Department at 1-833-891-9372; TTY: 711.

Additional Resources

If you have concerns about long-term nursing home care, choosing a nursing home, or the effect on your finances, there are additional resources to help.

- Independent Consumer Advocacy Network (ICAN) provides free and confidential assistance. Call 1-844-614-8800 or visit www.icannys.org.
- New York State Office for the Aging
  - Health Insurance Information, Counseling and Assistance (HIICAP) provides free counseling and advocacy on health insurance questions. Call 1-800-701-0501.

– NY CONNECTS is a link to long term service and supports. Call 1-800-342-9871 or visit www.nyconnects.ny.gov.

- Nursing Home Bill of Rights (NHBOR) describes your rights and responsibilities as a nursing home resident. To learn more about NHBOR, visit www.health.ny.gov/facilities/nursing/rights/.

Medically Tailored Meals (MTM)

Independent Health will cover Medically Tailored Meals for eligible adults 18 years or older.

Through this program, you and other members who qualify can get:

- Help from a registered dietitian and nutritionist. This person is a food and nutrition expert and will help give guidance and support in choosing healthy foods.
- Up to three meals per day delivered to your home for six months at a time. You may be able to continue receiving meals as long as you are eligible for this program. These meals are tailored for your specific health needs and can help you gain access to healthy, nutritious foods.

This program is offered to Independent Health Medicaid members who are 18 years of age or older. Members must have a secure place to store and heat meals, and:

- Receive personal care services. Member must choose to replace some of their meal prep and food shopping hours while getting a medically tailored meal. The hours reduced will depend on the number of meals you receive, **OR**
- Have cancer, diabetes, heart failure, or HIV/AIDS, and a certain number of inpatient hospital stays and/or emergency room (ER) visits within the last 12 months related to these conditions.

To learn more about these services, call Member Services at 716-250-7183 or 1-833-891-9372, TTY users call: 711.

BEHAVIORAL HEALTH CARE

Behavioral health care includes mental health and substance use (alcohol and drugs) treatment and rehabilitation services. All of our members have access to services to help with emotional health, or to help with alcohol or other substance use issues. These services include:

ADULT MENTAL HEALTH CARE

- Psychiatric Services
- Psychological Services
- Inpatient and outpatient mental health treatment
- Injections for Behavioral Health Related Conditions
- Partial hospitalization
- Rehab services if you are in a community home or in family-based treatment
- Individual and group counseling
- Crisis intervention services
- Comprehensive Psychiatric Emergency Program (CPEP) including Extended Observation Bed
- Assertive Community Treatment (ACT)
- Continuing Day Treatment
- Personalized Recovery Oriented Services (PROS)
-

ADULT SUBSTANCE USE DISORDER SERVICES

- Crisis Services
    - Medically managed withdrawal management
    - Medically supervised withdrawal management (inpatient/outpatient)
- Inpatient addiction treatment services (hospital or community based)
- Residential addiction treatment services
    - Stabilization in residential setting
    - Rehabilitation in residential setting
- Outpatient addiction treatment services
    - Intensive outpatient treatment
    - Outpatient rehabilitation services
    - Outpatient withdrawal management
    - Medication Assisted Treatment
- Opioid Treatment Programs (OTP)

HARM REDUCTION SERVICES

If you are in need of help related to substance use disorder, Harm Reduction Services can offer a complete patient- oriented approach to your health and well-being. Independent Health covers services that may help reduce sub- stance use and other related harms. These services include:

- A plan of care developed by a person experienced in working with substance.
- Individual supportive counseling that assists in achieving your goals.
- Group supportive counseling in a safe space to talk with others about issues that affect your health and well-being.
- Counseling to help you with taking your prescribed medication and continuing treatment.
- Support groups to help you better understand substance use and identify coping techniques and skills that will work for you.

To learn more about these services, call Member Services at (716)631-8701 or 1800-501-3439 (TTY users call 711), Monday – Friday, 8 a.m. – 8 p.m.

GAMBLING DISORDER TREATMENT PROVIDED BY OFFICE OF ADDICTION SERVICES AND SUPPORTS (OASAS) CERTIFIED PROGRAMS.

Independent Health covers Gambling Disorder Treatment provided by Office of Addiction Services and Supports (OASAS) certified programs.

You can get Gambling Disorder Treatment:

- face-to-face; or
- through telehealth.

If you need Gambling Disorder Treatment, you can get them from an OASAS outpatient program or if necessary, an OASAS inpatient or residential program.

You do not need a referral from your primary care provider (PCP) to get these services. If you need help finding a provider, please call Independent Health member services at the number listed below.

To learn more about these services, call Member Services at 716-250-7183 or 1-833-891-9372, TTY users call: 711

MENTAL HEALTH CARE FOR INDIVIDUALS UNDER AGE 21

Independent Health will cover more behavioral health services for children and youth. You can get these services by using your health plan card:

All Eligible Children Under Age 21

- Injections for Behavioral Health Related Conditions
- Family Peer Support Services
- Office of Mental Health (OMH) Outpatient Services
- Partial Hospitalization
- Psychiatric Services
- Psychological Services
- Comprehensive Psychiatric Emergency Program (CPEP) including Extended Observation Bed
- Inpatient Psychiatric Services
- Youth Peer Support and Training (YPST)
- Crisis intervention

Eligible Children Under Age 21 (minimum age of 18-20):

- Assertive Community Treatment (ACT)
- Continuing Day Treatment
- Personalized Recovery Oriented Services (PROS)

All Eligible Children Under Age 19:

- OMH designated Serious Emotional Disturbances (SED) Clinic Services

Substance Use Disorder for Individuals Under Age 21:

- Crisis Services
    - Medically managed withdrawal management
    - Medically supervised withdrawal management (inpatient/outpatient)
- Inpatient addiction treatment services (hospital or community based)
- Residential addiction treatment services

    - Stabilization in residential setting
    - Rehabilitation in residential setting
- Outpatient addiction treatment services
    - Intensive outpatient treatment
    - Outpatient rehabilitation services
    - Outpatient withdrawal management
    - Medication Assisted Treatment
- Opioid Treatment Programs (OTP)

Independent Health will cover these services for all eligible children and youth under age 21, including those:

- With Supplemental Security Income (SSI).
- Who have federal Social Security Disability Insurance (SSDI) status; or
- Who have been determined certified disabled by New York State Medical Disability Review.

CHILDREN'S FAMILY TREATMENT AND SUPPORT SERVICES (CFTSS)

Use your Independent Health benefit card to get Children and Family Treatment and Support Services. These services include:

- **Other Licensed Practitioner (OLP).** This benefit lets you get individual, group, or family therapy where you are most comfortable.
- **Psychosocial Rehabilitation (PSR).** This benefit helps you relearn skills to help you in your community. This service was called "Skill Building."
- **Community Psychiatric Supports and Treatment (CPST)**. This benefit helps you stay in your home and communicate better with family, friends, and others. This service was called "Intensive In Home Services," "Crisis Avoidance Management & Training," or "Intensive In Home Supports and Services."

Independent Health covers more Children and Family Treatment and Support Services (CFTSS). These services help children, and their families improve their health, well-being, and quality of life.

CFTSS are for children under age 21 with behavioral health needs. These services may be provided at home or in the community. The additional CFTSS services available includes:

- **Youth Peer Support and Training.** This benefit is provided by a credentialed Youth Peer Advocate, or Certified Recovery Peer Advocate with a youth focus who has similar experiences.
- **Family Peer Support Services (FPSS).** FPSS provide a structured, strength-based relationship between a Family Peer Advocate (FPA) and the parent/family member/caregiver for the benefit of the child/youth. Service components include activities to help the families to develop resources and supports for the benefit of the child/youth, including engagement, bridging and transition, self-advocacy, self-efficacy and empowerment, parent skill development, and community connections.

Get support and assistance with:

- Developing skills to manage health challenges and be independent.
- Feeling empowered to make decisions
- Making connections to natural supports and resources
- Transitioning to the adult health system when the time is right.

- **Crisis Intervention.** Professional help at home or in the community when a child or youth is distressed and can't be helped by family, friends, and other supports. Including support and help with using crisis plans to de-escalate the crisis and prevent or reduce future crises.

These services may already be covered by Independent Health for certain eligible children under age 21. If you are getting these services now, your care will not change.

To learn more about these services, call Member Services at (716) 631-8701 or 1-833-891-9372, Monday through Friday from 8 a.m. to 8 p.m. (TTY: 711)

CHILDREN'S HOME AND COMMUNITY BASED SERVICES.

New York State covers Children's Home and Community Based Services (HCBS) under the Children's Waiver. Independent Health covers children's HCBS for members participating in the Children's Waiver and provide care management for these services.

Children's HCBS offer personal, flexible services to meet the needs of each child/youth. HCBS is provided where children/youth and families are most comfortable and supports them as they work towards goals and achievements.

Who can get Children's HCBS?

Children's HCBS are for children and youth who:

- Need extra care and support to remain at home/in the community
- Have complex health, developmental and/or behavioral health needs
- Want to avoid going to the hospital or a long-term care facility
- Are eligible for HCBS and participate in the Children's Waiver

Members under age 21 will be able to get these services from their health plan:

- Community Habilitation
- Day Habilitation
- Caregiver/Family Support and Services
- Community Self Advocacy Training and Support
- Prevocational Services- *must be age 14 and older*
- Supported Employment- *must be age 14 and older*
- Respite Services (Planned Respite and Crisis Respite)
- Palliative Care
- Environmental Modifications
- Vehicle Modifications
- Adaptive and Assistive Equipment
- Youth Peer Support Services and Training
- Crisis Intervention

Children/youth participating in the Children's Waiver must receive care management. Care management provides a person who can help you find and get the services that are right for you.

- If you are getting care management from a Health Home Care Management Agency (CMA), you can stay with your CMA. Independent Health will work with your CMA to help you get the services you need.

- If you are getting care management from the Children and Youth Evaluation Service (C-YES), Independent Health will work with C-YES and provide your care management.

CRISIS RESIDENCE SERVICES FOR CHILDREN AND ADULTS

Independent Health covers Crisis Residence services. These are overnight services. These services treat children and adults who are having an emotional crisis. These services include:

Residential Crisis Support

This is a program for people who are age 18 or older with symptoms of emotional distress. These symptoms cannot be managed at home or in the community without help.

Intensive Crisis Residence

This is a treatment program for people who are age 18 or older who are having severe emotional distress.

Children's Crisis Residence

This is a support and treatment program for people under age 21. These services help people cope with an emotional crisis and return to their home and community.

To learn more about these services, call Member Services at 716-250-7183 or 1-833-891-9372, TTY users call: 711.

ARTICLE 29-I VOLUNTARY FOSTER CARE AGENCY (VFCA) HEALTH FACILITY SERVICES

Independent Health covers Article 29-I VFCA Health Facility services for children and youth under age 21.

29-I VFCA Health Facilities work with families to promote well-being and positive outcomes for children in their care. 29-I VFCA Health Facilities use trauma informed

practices to meet the unique needs of each child.

29-I VFCA Health Facilities may only serve children and youth referred by the local

district of social services.

The 29-I VFCA Health Facility services available on include:

Core Limited Health-Related Services

1. Skill Building

2. Nursing Supports and Medication Management

3. Medicaid Treatment Planning and Discharge Planning

4. Clinical Consultation and supervision

5. Managed Care Liaison/Administration

And

Other Limited Health-Related Services

1. Screening, diagnosis, and treatment services related to physical health

2. Screening, diagnosis, and treatment services related to developmental and behavioral health

3. Children and Family Treatment and Support Services (CFTSS)

4. Children's Home and Community Based Services (HCBS)

Independent Health will cover Core Limited Health Related Services for children and youth placed with a 29-I VFCA Health Facility.

Independent Health and Carelon Behavioral Health will cover Other Limited Health Related Services provided by 29-I VFCA Health Facilities to eligible children and youth.

To learn more about these services, call Member Services at 716-250-7183 or 1-800-501-3439, TTY users call: 711.

APPLIED BEHAVIOUR ANALYSIS (ABA) SERVICES

Independent Health covers Applied Behavior Analysis (ABA) therapy provided by:

- Licensed Behavioral Analyst (LBA), or
- Certified Behavioral Analyst Assistant (CBAA) under the supervision of an LBA.

Who can get ABA?
Children/youth under the age of 21 with a diagnosis of autism spectrum disorder and/or Rett Syndrome. If you think you are eligible to get ABA services, talk to your provider about this service. Independent Health will work with you and your provider to make sure you get the service you need.

The ABA services include:

- assessment and treatment by a physician, licensed behavioral analyst, or certified behavior analyst assistant,
- individual treatments delivered in the home or other setting,
- group adaptive behavior treatment, and
- training and support to family and caregivers.

To learn more about these services, call Member Services at 716-250-7183 or 1-833-891-9372, TTY users call: 711.

NATIONAL DIABETES PREVENTION PROGRAM (NDPP)

If you are at risk for developing Type 2 diabetes, Independent Health covers services that may help.

Independent Health covers diabetes prevention services through the National Diabetes Prevention Program (NDPP). This benefit will cover 22 NDPP group training sessions over the course of 12 months.

The **National Diabetes Prevention Program** is an educational and support program designed to assist at-risk people from developing Type 2 diabetes. The program consists of group training sessions that focus on the long-term, positive effects of healthy eating and exercise. The goals for these lifestyle changes include modest weight loss and increased physical activity. NDPP sessions are taught using a trained lifestyle coach.

Eligibility

You may be eligible for diabetes prevention services if you have a recommendation by a physician or other licensed practitioner and are:

- At least 18 years old,
- Not currently pregnant,
- Overweight, and

- Have not been previously diagnosed with Type 1 or Type 2 Diabetes.

And you meet one of the following criteria:

- You have had a blood test result in the prediabetes range within the past year, **or**
- You have been previously diagnosed with gestational diabetes, **or**
- You score 5 or higher on the CDC/American Diabetes Association (ADA) Prediabetes Risk Test.

Talk to your doctor to see if you qualify to take part in the NDPP.

To learn more about these services, call Member Services at (716) 631-8701 or 1-833-891-9372, Monday through Friday from 8 a.m. to 8 p.m. (TTY: 711).

BROOK+ DIABETES PREVENTION PROGRAM

If you are at risk for developing type 2 diabetes, Independent Health covers services that may be able to help you. Independent Health covers Brook+, a Centers for Disease Control and Prevention (CDC)-recognized diabetes prevention program that helps people make lifestyle changes so that they can reduce their risk for type 2 diabetes, achieve a healthy weight, and improve their overall health. This program is voluntary and will be available at no cost to eligible members.

Brook+ is completely digital using a smartphone, tablet or computer. No phone calls or appointments are necessary. All participants receive one-on-one help from a personal health coach and have access to group support, too.

Eligibility

You may be eligible for the Brook+ program if you:

• Are at least 18 years old,

• Are not currently pregnant,

• Are overweight,

• Have not been previously diagnosed with type 1 or type 2 diabetes, and

• Do not have End Stage Renal Disease.

And you meet one of the following criteria:

• You have had a blood test result in the prediabetes range within the past year, or

• You have been previously diagnosed with gestational diabetes, or

• You score 5 or higher on the CDC/American Diabetes Association (ADA) Prediabetes Risk Test.

To check if you are eligible for Brook+, please visit bit.ly/brookdpp on or after October 1 st , 2022.

Independent Health is here for you! If you have any questions, please call our Member Services Department at (716) 631- 8701 or 1-833-891-9372, Monday through Friday from 8 a.m. to 8 p.m. (TTY: 711).

INFERTILITY SERVICES

If you are unable to get pregnant, Independent Health covers services that may help.

Independent Health covers some drugs for infertility. This benefit will be limited to coverage for 3 cycles of treatment per lifetime.

Independent Health will also cover services related to prescribing and monitoring the use of such drugs. The infertility benefit includes:

- Office visits
- X-ray of the uterus and fallopian tubes
- Pelvic ultrasound
- Blood testing

Eligibility

You may be eligible for infertility services if you meet the following criteria:

- You are 21-34 years old and are unable to get pregnant after 12 months of regular, unprotected sex.
- You are 35-44 years old and are unable to get pregnant after 6 months of regular, unprotected sex.

To learn more about these services, call Member Services at (716) 631-8701 or 1-833-891-9372. TTY users can call: 711

BENEFITS YOU CAN GET FROM MEDISOURCE OR WITH YOUR MEDICAID CARD

For some services, you can choose where to get the care. You can get these services by using your MediSource membership card. You can also go to providers who will take your Medicaid Benefit card. You do not need a referral from your PCP to get these services. Call us if you have questions at 1-833-891-9372.

FAMILY PLANNING

You can go to any doctor or clinic that takes Medicaid and offers family planning services. You can visit one of our family planning providers as well. Either way, you do not need a referral from your PCP.

You can get birth control drugs, birth control devices (IUDs and diaphragms) that are available with a prescription, plus emergency contraception, sterilization, pregnancy testing, prenatal care, and abortion services. You can also see a family planning provider for HIV and sexually transmitted infection (STI) testing and treatment and counseling related to your test results. Screenings for cancer and other related conditions are also included in family planning visits.

HIV AND STI SCREENING

You can get this service any time from your PCP or MediSource doctors. When you get this service as part of a family planning visit, you can go to any doctor or clinic that takes Medicaid and offers family planning services. You do not need a referral when you get this service as part of a family planning visit.

Everyone should talk to their doctor about having an HIV test. To access free HIV testing or testing where your name isn't given, call 1-800-541-AIDS (English) or 1-800-233-SIDA (Spanish).

TB DIAGNOSIS AND TREATMENT

You can choose to go either to your PCP or to the county public health agency for diagnosis and/or treatment. You do not need a referral to go to the county public health agency.

BENEFITS USING YOUR MEDICAID CARD ONLY

There are some services MediSource does not provide. You can get these services from a provider who takes Medicaid by using your Medicaid Benefit card.

TRANSPORTATION

Emergency and/or non-emergency medical transportation will be covered by regular Medicaid. To get non-emergency transportation, you or your provider must call Medical Answering Services (MAS) at 1-800-651-7040. If possible, you or your provider should call MAS at least 3 days before your medical appointment and provide your Medicaid identification number (ex. AB12345C), appointment date and time, address where you are going, and doctor you are seeing. Non-emergency medical transportation includes personal vehicle, bus, taxi, ambulette and public transportation.

If you have an emergency and need an ambulance, you must call 911.

DEVELOPMENTAL DISABILITIES

- Long-term therapies
- Day treatment
- Housing services
- Medicaid Service Coordination (MSC) program
- Services received under the Home and Community Based Services Waiver
- Medical Model (Care-at-Home) Waiver Services

SERVICES NOT COVERED

These services are not available from MediSource or Medicaid. If you get any of these services, you may have to pay the bill.

- Cosmetic surgery if not medically needed.
- Personal and comfort items.

- Services from a provider that is not part of MediSource, unless it is a provider you are allowed to see as described elsewhere in this handbook or Independent Health or your PCP send you to that provider.
- Services for which you need a referral (approval) in advance, and you did not get it.
- Drugs when used to treat erectile dysfunction.

You may have to pay for any service that your PCP does not approve. Or, if before you get a service, you agree to be a "private pay" or "self-pay" patient you will have to pay for the service. This includes:

- Non-covered services (listed above).
- Unauthorized services.

Services provided by providers not part of MediSource.

IF YOU GET A BILL

If you get a bill for a treatment or service you do not think you should pay for, do not ignore it. Call Independent Health at 1-833-891-9372 right away. Independent Health can help you understand why you may have gotten a bill. If you are not responsible for payment, Independent Health will contact the provider and help fix the problem for you.

You have the right to ask for fair hearing if you think you are being asked to pay for something Medicaid or MediSource should cover. See the Fair Hearing section later in this handbook.

If you have any questions, call Member Services at 1-833-891-9372.

SERVICE AUTHORIZATION

PRIOR AUTORIZATION

There are some treatments and services that you need to get approval for before you receive them or in order to be able to continue receiving them. This is called **prior authorization**. You or someone you trust can ask for this. The following treatments and services must be approved before you get them:

- Out-of-Plan Services
- Subacute/Skilled Nursing Home Admissions
- Adult Day Health Care

- Home Care Services
- Personal Care Services
- Personal Emergency Response System (PERS)
- Mental Health
- Durable Medical Equipment
- Medical Supplies
- Prosthetics and Appliances
- Certain Surgical Procedures

Asking for approval of a treatment or service is called a **service authorization request**. To get approval for these treatments or services you need to:

- Have your doctor or health care provider call Independent Health's Utilization Management Department to request authorization. Your doctor needs to get telephone approval of many elective surgeries at least 7 days before you go to the hospital.
- Emergent hospital admissions require hospital notification within 24 hours of the admission occurring through the emergency room. Our nurses obtain the clinical information through an interview process with your doctor to determine the medical necessity for the elective/emergent hospital admission.

You will also need to get prior authorization if you are getting one of these services now but need to continue or get more of the care. This is called **concurrent review.**

What happens after we get your service authorization request?

The health plan has a review team to be sure you get the services we promise. We check that the service you are asking for is covered under your health plan. Doctors and nurses are on the review team. Their job is to be sure the treatment or service you asked for is medically needed and right for you. They do this by checking your treatment plan against medically acceptable standards.

We may decide to deny a service authorization request or to approve it for an amount that is less than requested. These decisions will be made by a qualified health care professional. If we decide that the requested service is not medically necessary, the decision will be made by a clinical peer reviewer, who may be a doctor or may be a health care professional who typically

provides the care you requested. You can request the specific medical standards, called clinical review criteria, we use to make decisions about medical necessity.

After we get your request we will review it under a standard or fast track process. You or your doctor can ask for a fast track review if it is believed that a delay will cause serious harm to your health. If your request for a fast track review is denied, we will tell you and your case will be handled under the standard review process.

We will fast track your review if:

- A delay will seriously risk your health, life, or ability to function.
- Your provider says the review must be faster:
- You are asking for more a service you are getting right now.

In all cases, we will review your request as fast as your medical condition requires us to do so but no later than mentioned below.

We will tell you and your provider both by phone and in writing if your request is approved or denied. We will also tell you the reason for the decision. We will explain what options for appeals or fair hearings you will have if you don't agree with our decision. (See also the Plan Appeals and Fair Hearing sections later in this handbook.)

Timeframes for prior authorization requests:

- **Standard review**: We will make a decision about your request within 3 workdays of when we have all the information we need, but you will hear from us no later than 14 days after we receive your request. We will tell you by the 14th day if we need more information.
- **Fast track review**: We will make a decision within 1 workday of when we have all the information we need. You will hear from us no later than 72 hours after we received your request. We will tell you within 1 workday if we need more information

Timeframes for concurrent review requests:

- **Standard review**: We will make a decision within 1 workday of when we have all the information we need, but you will hear from us no later than 14 days after we received your request. We will tell you by the 14th day if we need more information.
- **Fast track review**: We will make a decision and you will hear from us within 72 hours. We will tell you within 72 hours if we need more information.

Special timeframes for other requests:

- If you are in the hospital or have just left the hospital and you are asking for home health care we will make a decision within 72 hours of your request.
- If you are getting inpatient substance use disorder treatment, and you ask for more services at least 24 hours before you are to be discharged, we will make a decision within 24 hours of your request.
- If you are asking for mental health or substance use disorder services that may be related to a court appearance, we will make a decision within 72 hours of your request.
- If you are asking for an outpatient prescription drug we will make a decision within 24 hours of your request.
- A step therapy protocol means we require you to try another drug first before we will approve the drug you are requesting. If you are asking for approval to override a step therapy protocol, we will make a decision with 24 hours for outpatient prescription drugs. For other drugs, we will make a decision within 14 days of your request.

If we need more information to make either a standard or fast track decision about your service request we will:

- Write and tell you what information is needed. If your request is in a fast track review, we will call you right away and send a written notice later.
- Tell you why the delay is in your best interest.
- Make a decision no later than 14 days from the day we asked for more information.

You, your provider, or someone you trust may also ask us to take more time to make a decision. This may be because you have more information to give the plan to help decide your case. This can be done by calling 1-833-891-9372 or writing to:

Independent Health

511 Farber Lakes Drive

Buffalo, NY 14221

You or your representative can file a complaint with the plan if you don't agree with our decision to take more time to review your request. You or someone you trust can also file a complaint about the review time with the New York State Department of Health by calling 1-800-206-8125.

We will notify you by the date our time for review has expired. But if for some reason you do not hear from us by that date, it is the same as if we denied your service authorization request. If we do not respond to a request to override a step therapy protocol on time, your request will be approved.

If you think our decision to deny your service authorization request is wrong, you have the right to file a Plan Appeal with us. See the Plan Appeal section later in this handbook.

Other Decisions About Your Care:

Sometimes we will do a concurrent review on the care you are receiving to see if you still need the care. We may also review other treatments and services you have already received. This is called **retrospective review**. We will tell you if we make these decisions

Timeframes for other decisions about your care

In most cases, if we make a decision to reduce, suspend or stop a service we have already approved and you are now getting, we must tell you at least 10 days before we change the service.

- We must tell you at least 10 days before we make any decision about long term services and supports, such as home health care, personal care, CDPAS, adult day health care, and nursing home care.
- If we are checking care that has been given in the past, we will make a decision about paying for it within 30 days of receiving all information we need for the retrospective review. If we deny payment for a service, we will send a notice to you and your provider the day the payment is denied. These notices are not bills. **You will not have to pay for any care you received that was covered by the plan or by Medicaid even if we later deny payment to the provider.**

HOW OUR PROVIDERS ARE PAID

You have the right to ask us whether we have any special financial arrangement with our physicians that might affect your use of health care services. You can call Member Services at 1-833-891-9372 if you have specific concerns. We also want you to know that most of our providers are paid in one or more of the following ways.

- If our PCPs work in a clinic or health center, they probably get a **salary**. The number of patients they see does not affect this.

- Our PCPs who work from their own offices may get a set fee each month for each patient for whom they are the patient's PCP. The fee stays the same whether the patient needs one visit or many – or even none at all. This is called **capitation**.
- Sometimes providers get a set fee for each person on their patient list, but some money (maybe 10%) can be held back for an **incentive** fund. At the end of the year, this fund is used to reward PCPs who have met the standards for extra pay that were set by Independent Health.
- Providers may also be paid by **fee-for-service**. This means they get a MediSource-agreed-upon fee for each service they provide.

YOU CAN HELP WITH PLAN POLICIES

We value your ideas. You can help us develop policies that best serve our members. If you have ideas tell us about them. Maybe you'd like to work with one of our member advisory boards or committees. Call Member Services at 1-833-891-9372 to find out how you can help.

INFORMATION FROM MEMBER SERVICES

Here is information you can get by calling Member Services at 1-833-891-9372:

- A list of names, addresses, and titles of Independent Health's Board of Directors, Officers, Controlling Parties, Owners and Partners.
- A copy of the most recent financial statements/balance sheets, summaries of income and expenses.
- A copy of the most recent individual direct pay subscriber contract.
- Information from the Department of Financial Services about consumer complaints about Independent Health.
- How we keep your medical records and member information private.
- In writing, we will tell you how Independent Health checks on the quality of care to our members.
- We will tell you which hospitals our health providers work with.
- If you ask us in writing, we will tell you the guidelines we use to review conditions or diseases that are covered by MediSource.

KEEP US INFORMED

Call Member Services at 1-833-891-9372 whenever these changes happen in your life:

- You change your name, address, or telephone number.
- You have a change in Medicaid eligibility.
- You are pregnant.
- You give birth.
- There is a change in insurance for you or your children.

If you no longer get Medicaid, check with your local Department of Social Services. You *may* be able to enroll in another program.

DISENROLLMENT AND TRANSFERS

1. If YOU Want to Leave the Plan

You can try us out for 90 days. You may leave MediSource and join another health plan at any time during that time. If you do not leave in the first 90 days, however, you must stay in MediSource for nine more months, unless you have a good reason (good cause).

Some examples of good cause include:

- Our health plan does not meet New York State requirements and members are harmed because of it.
- You move out of our service area.
- You, Independent Health, and the LDSS all agree that disenrollment is best for you.
- You are or become exempt or excluded from managed care.
- We do not offer a Medicaid managed care service that you can get from another health plan in your area.
- You need a service that is related to a benefit we have chosen not to cover and getting the service separately would put your health at risk.
- We have not been able to provide services to you as we are required to under our contract with the state.

To change plans:

If you live in Erie County, call New York Medicaid Choice at 1-800-505-5678. The New York Medicaid Choice counselors can help you change health plans.

You may be able to transfer to another plan over the phone. If you have to be in managed care, you will have to choose another health plan.

It may take between two and six weeks to process, depending on when your request is received. You will get a notice that the change will take place by a certain date. MediSource will provide the care you need until then.

You can ask for faster action if you believe the timing of the regular process will cause added damage to your health. You can also ask for faster action if you have complained because you did not agree to the enrollment. Just call your local Department of Social Services or New York Medicaid Choice.

2. You Could Become Ineligible for Medicaid Managed Care and Health and Recovery Plans

You or your child may have to leave MediSource if you or the child:

- Move out of the county or service area.
- Change to another managed care plan.
- Join an HMO or other insurance plan through work.
- Go to prison.
- Otherwise lose eligibility.

Your child may have to leave MediSource or change plans if he or she:

- Joins a Physically Handicapped Children's Program, or
- Is placed in foster care by the local Department of Social Services in an area that is not served by your child's current plan.

If you have to leave Independent Health or become ineligible for Medicaid, all of your services may stop unexpectedly, including any care you receive at home. Call New York Medicaid Choice at 1-800-505-5678 right away if this happens.

3. We Can Ask You to Leave Independent Health

You can also lose your MediSource membership if you often:

- Refuse to work with your PCP in regard to your care.
- Don't keep appointments.
- Go to the emergency room for non-emergency care.
- Don't follow Independent Health's rules.
- Do not fill out forms honestly or do not give true information (commit fraud).
- Cause abuse or harm to plan members, providers, or staff.
- Act in ways that make it hard for us to do our best for you and other members even after we have tried to fix the problems.

PLAN APPEALS

There are some treatments and services that you need to get approval for before you receive them or in order to be able to continue receiving them. This is called **prior authorization**. Asking for approval of a treatment or service is called a **service authorization request**. This process is described earlier in this handbook. The notice of our decision to deny a service authorization request or to approve it for an amount that is less than requested is called an **Initial Adverse Determination**. If you are not satisfied with our decision about your care, there are steps you can take.

Your provider can ask for reconsideration:

If we made a decision that your service authorization request was not medically necessary or was experimental or investigational; and we did not talk to your doctor about it, your doctor may ask to speak with the plan's Medical Director. The Medical Director will talk to your doctor within one workday.

You can file a Plan Appeal:

If you think our decision about your service authorization request is wrong, you can ask us to look at your case again. This is called a **Plan Appeal.**

- You have **60 calendar days** from the date of the Initial Adverse Determination notice to ask for a Plan Appeal

- You can call Member Services at 1-833-891-9372, TTY/TDD users call, 711 if you need help asking for a Plan Appeal or following the steps of the appeal process. We can help if you have any special needs like a hearing or vision impairment, or if you need translation services.
- You can ask for a Plan Appeal, or you can have someone else, like a family member, friend, doctor, or lawyer, ask for you. You and that person will need to sign and date a statement saying you want that person to represent you.
- We will not treat you any differently or act badly toward you because you ask for a Plan Appeal.

AID TO CONTINUE WHILE APPEALING A DECISION ABOUT YOUR CARE:

If we decided to reduce, suspend, or stop services you are getting now, you may be able to continue the services while you wait for your Plan Appeal to be decided.

You must ask for your Plan Appeal:

- **Within ten days from being told that your request is denied, or care is changing: or**
- **By the date the change in services is scheduled to occur, whichever is later.**

If your Plan Appeal results in another denial you may have to pay for the cost of any continued benefits that you received.

You can call, write, or visit us to ask for a Plan Appeal. When you ask for a Plan Appeal, or soon after, you will need to give us:

- Your name and address
- Enrollee number
- Service you asked for and reason(s) for appealing
- Any information that you want us to review, such as medical records, doctors' letters or other information that explains why you need the service.
- Any specific information we said we needed in the Initial Adverse Determination notice.
- To help you prepare for your Plan Appeal, you can ask to see the guidelines, medical records, and other documents we used to make the Initial Adverse Determination. If your Plan Appeal is fast tracked, there may be a short time to give us information you want us to review. You can ask to see these documents or ask for a free copy by calling 1-833-891-9372, TTY/TDD users call, 711.

Give us your information and materials by phone, fax, email, mail, online or in person:

Phone…….. 1-833-891-9372, TTY/TDD: 711
Fax……716-635-3504
Email…… appeals@independenthealth.com
Mail……..P.O. Box 2090, Buffalo, NY 14231
Online……www.independenthealth.com
In Person……..250 Essjay Road, Buffalo, NY, 14221

If you ask for your Plan Appeal by phone, unless it is fast tracked, you must also send your Plan Appeal to us in writing. After your call, we will send you a form which is a summary of your phone Plan Appeal. If you agree with our summary, you should sign and return the form to us. You can make any needed changes before sending the form back to us.

If you are asking for out of network service or provider:

- If we said that the service you asked for is not very different from a service available from a participating provider, you can ask us to check if this service is medically necessary for you. You will need to ask your doctor to send this information with your Plan Appeal:
    1) a statement in writing from your doctor that the out of network service is very different from the service the plan can provide from a participating provider. Your doctor must be a board certified or board eligible specialist who treats people who need the service you are asking for.
    2) two medical or scientific documents that prove the service you are asking for is more helpful to you and will not cause you more harm than the service the plan can provide from a participating provider. If your doctor does not send this information, we will still review your Plan Appeal. However, you may not be eligible for an External Appeal. See the External Appeal section later in this handbook.
- lf you think our participating provider does not have the correct training or experience to provide a service, you can ask us to check if it is medically necessary for you to be referred to an out of network provider. You will need to ask your doctor to send this information with your appeal:
    1) a statement in writing that says our participating provider does not have the correct training and experience to meet your needs, and
    2) that recommends an out of network provider with the correct training and experience who is able to provide the service.

Your doctor must be a board certified or board eligible specialist who treats people who need

the service you are asking for.

If your doctor does not send this information, we will still review your Plan Appeal. However, you may not be eligible for an External Appeal. See the External Appeal section later in this handbook.

What happens after we get your Plan Appeal?

- Within 15 days, we will send you a letter to let you know we are working on your Plan Appeal.
- We will send you a free copy of the medical records and any other information we will use to make the appeal decision. If your Plan Appeal is fast tracked, there may be a short time to review this information.
- You can also provide information to be used in making the decision in person or in writing. Call Independent Health at 1-833-891-9372, TTY/TDD users call, 711 if you are not sure what information to give us.
- Plan Appeals of clinical matters will be decided by qualified health care professionals who did not make the first decision, at least one of whom will be a clinical peer reviewer.
- Non-clinical decisions will be handled by persons who work at a higher level than the people who worked on your first decision.
- You will be given the reasons for our decision and our clinical rationale if it applies. The notice of the Plan Appeal decision to deny your request or to approve it for an amount that is less than requested is called a **Final Adverse Determination.**

If you think our Final Adverse Determination is wrong:

- You can ask for a Fair Hearing. See the Fair Hearing section of this handbook.
- For some decisions, you may be able to ask for an External Appeal. See the External Appeal section of this handbook.
- You may file a complaint with the New York State Department of Health at 1-800-206-8125.

Timeframes for Plan Appeals:

- **Standard Plan Appeals**: If we have all the information we need we will tell you our decision within 30 calendar days from when you asked for your Plan Appeal.
- **Fast track Plan Appeals**: If we have all the information we need, fast track Plan Appeal decisions will be made in 2 working days from your Plan Appeal but not more than 72 hours from when you asked for your Plan Appeal.

- We will tell you within in 72 hours if we need more information.
- If your request was denied when you asked for more inpatient substance use disorder treatment at least 24 hours before you were to leave the hospital, we will make a decision about your appeal within 24 hours.
- We will tell you our decision by phone and send a written notice later.

Your Plan Appeal will be reviewed under the fast track process if:

- If you or your doctor asks to have your Plan Appeal reviewed under the fast track process. Your doctor would have to explain how a delay will cause harm to your health. If your request for fast track is denied we will tell you and your Plan Appeal will be reviewed under the standard process; or
- If your request was denied when you asked to continue receiving care that you are now getting or need to extend a service that has been provided; or
- If your request was denied when you asked for home health care after you were in the hospital; or
- If your request was denied when you asked for more inpatient substance use disorder treatment at least 24 hours before you were to leave the hospital.

If we need more information to make either a standard or fast track decision about your Plan Appeal we will:

- Write you and tell you what information is needed. If your request is in a fast track review, we will call you right away and send a written notice later.
- Tell you why the delay is in your best interest.
- Make a decision no later than 14 days from the day we asked for more information.

You or your representative may also ask us to take more time to make a decision. This may be because you have more information to give the plan to help decide your case. This can be done by calling 1-833-891-9372, TTY/TDD users call, 711 or writing.

You or your representative can file a complaint with the plan if you don't agree with our decision to take more time to review your Plan Appeal. You or someone you trust can also file a complaint about the review time with the New York State Department of Health by calling 1-800-206-8125.

If you do not receive a response to your Plan Appeal or we do not decide in time, including extensions, you can ask for a Fair Hearing. See the Fair Hearing section of this handbook.

If we do not decide your Plan Appeal on time, and we said the service you are asking for is:

1) Not medically necessary.
2) Experimental or investigational.
3) Not different from care you can get in the plan's network; or
4) Available from a participating provider who has correct training and experience to meet your needs, the original denial will be reversed. This means your service authorization request will be approved

External Appeals

You have other appeal rights if we said the service you are asking for was:

1) not medically necessary.
2) experimental or investigational.
3) not different from care you can get in the plan's network; or
4) available from a participating provider who has correct training and experience to meet your needs.

For these types of decisions, you can ask New York State for an independent **External Appeal**. This is called an External Appeal because it is decided by reviewers who do not work for the health plan or the state. These reviewers are qualified people approved by New York State. The service must be in the plan's benefit package or be an experimental treatment, clinical trial, or treatment for a rare disease. You do not have to pay for an External Appeal.

Before you ask for an External Appeal:

- You must file a Plan Appeal and get the plan's Final Adverse Determination; **or**
- If you have not gotten the service, and you ask for a fast track Plan Appeal, you may ask for an

expedited External Appeal at the same time. Your doctor will have to say an expedited External Appeal is necessary; **or**

- You and the plan may agree to skip the plan's appeals process and go directly to External Appeal; **or**
- You can prove the plan did not follow the rules correctly when processing your Plan Appeal.

You have 4 months after you receive the plan's Final Adverse Determination to ask for an External Appeal. If you and the plan agreed to skip the plan's appeals process, then you must ask for the External Appeal within 4 months of when you made that agreement.

To ask for an External Appeal, fill out an application and send it to the Department of Financial Services. You can call Member Services at 1-833-891-9372, TTY/TDD users call, 711 if you need help filing an appeal. You and your doctors will have to give information about your medical

problem. The External Appeal application says what information will be needed.

Here are some ways to get an application:

- Call the Department of Financial Services, 1-800-400-8882
- Go to the Department of Financial Services' web site at www.dfs.ny.gov.
- Contact the health plan at 1-833-891-9372, TTY/TDD users call, 1-800-432-1110

Your External Appeal will be decided in 30 days. More time (up to five workdays) may be needed if the external appeal reviewer asks for more information. You and the plan will be told the final decision within two days after the decision is made.

You can get a faster decision if:

- Your doctor says that a delay will cause serious harm to your health: or
- You are in the hospital after an emergency room visit and the hospital care is denied by the plan.

This is called an **expedited External Appeal**. The External Appeal reviewer will decide an expedited appeal in 72 hours or less.

If you asked for inpatient substance use disorder treatment at least 24 hours before you were to leave the hospital, we will continue to pay for your stay if:

- you ask for a fast track Plan Appeal within 24 hours, AND
- you ask for a fast track External Appeal at the same time.

We will continue to pay for your stay until there is a decision made on your appeals. We will make a decision about your fast track Plan Appeal in 24 hours. The fast track External Appeal will be decided in 72 hours.

The External Appeal reviewer will tell you and the plan the decision right away by phone or fax. Later, a letter will be sent that tells you the decision.

If you ask for a Plan Appeal, and you receive a Final Adverse Determination that denies, reduces, suspends, or stops your service, you can ask for a Fair Hearing. You may ask for a Fair Hearing or ask for an External Appeal, or both. If you ask for both a Fair Hearing and an External Appeal, the decision of the fair hearing officer will be the one that counts.

You can get a faster decision if:

- Your doctor says that a delay will cause serious harm to your health: or
- You are in the hospital after an emergency room visit and the hospital care is denied by the plan.

This is called an **expedited External Appeal**. The External Appeal reviewer will decide an expedited appeal in 72 hours or less.

If you asked for inpatient substance use disorder treatment at least 24 hours before you were to leave the hospital, we will continue to pay for your stay if:

- You ask for a fast track Plan Appeal within 24 hours, AND

- You ask for a fast track External Appeal at the same time.

We will continue to pay for your stay until there is a decision made on your appeals. We will make a decision about your fast track Plan Appeal in 24 hours. The fast track External Appeal will be decided in 72 hours.

The External Appeal reviewer will tell you and the plan the decision right away by phone or fax. Later, a letter will be sent that tells you the decision.

If you ask for a Plan Appeal, and you receive a Final Adverse Determination that denies, reduces, suspends, or stops your service, you can ask for a Fair Hearing. You may ask for a Fair Hearing or ask for an External Appeal, or both. If you ask for both a Fair Hearing and an External Appeal, the decision of the fair hearing officer will be the one that counts.

Fair Hearings

You may ask for a Fair Hearing from New York State if:

- You are not happy with a decision your local Department of Social Services, or the State Department of Health made about your staying or leaving Independent Health.
- You are not happy with a decision we made to restrict your services. You feel the decision limits your Medicaid benefits. You have 60 calendar days from the date of the Notice of Intent to Restrict to ask for a Fair Hearing. If you ask for a Fair Hearing within 10 days of the Notice of Intent to Restrict, or by the effective date of the restriction, whichever is later, you can continue to get your services until the Fair Hearing decision. However, if you lose your Fair Hearing, you may have to pay the cost for the services you received while waiting for the decision.
- You are not happy with a decision that your doctor would not order services you wanted. You feel the doctor's decision stops or limits your Medicaid benefits. You must file a complaint with Independent Health. If Independent Health agrees with your doctor, you may ask for a Plan Appeal. If you receive a Final Adverse Determination, you will have 120 calendar days from the date of the Final Adverse Determination to ask for a state Fair Hearing.
  - You are not happy with a decision that we made about your care. You feel the decision limits your Medicaid benefits. You are not happy we decided to:
    - reduce, suspend, or stop care you were getting; or
    - deny care you wanted.
    - deny payment for care you received; or
    - did not let you dispute a co-pay amount, other amount you owe or payment you made for your health care.
  - You asked for a Plan Appeal, and the time for us to decide your Plan Appeal has expired, including any extensions. If you do not receive a response to your Plan Appeal or we do not decide in time, you can ask for a Fair Hearing

You must first ask for a Plan Appeal and receive a Final Adverse Determination. You will have 120 calendar days from the date of the Final Adverse Determination to ask for a Fair Hearing.

If you asked for a Plan Appeal, and receive a Final Adverse Determination that reduces, suspends, or stops care you getting now, you can continue to get the services your doctor ordered while you wait for your Fair Hearing to be decided. You must ask for a fair hearing within 10 days from the date of the Final Adverse Determination or by the time the action takes effect, whichever is later. However, if you choose to ask for services to be continued, and you lose your Fair Hearing, you may have to pay the cost for the services you received while waiting for a decision.

The decision you receive from the fair hearing officer will be final.

You can use one of the following ways to request a Fair Hearing:

1. By phone – call toll-free 1-800-342-3334 2.
2. By fax – 518-473-6735
3. By internet – www.otda.state.ny.us/oah/forms.asp
4. By mail – NYS Office of Temporary and Disability Assistance

Office of Administrative Hearings
Managed Care Hearing Unit
P.O. Box 22023
Albany, New York 12201-2023

When you ask for a Fair Hearing about a decision Independent Health made, we must send you a copy of the **evidence packet**. This is information we used to make our decision about your care. The plan will give this information to the hearing officer to explain our action. If there is not time enough to mail it to you, we will bring a copy of the evidence packet to the hearing for you. If you do not get your evidence packet by the week before your hearing, you can call 1-833-891-9372, TTY/TDD users call, 711 to ask for it.

Remember, you may complain anytime to the New York State Department of Health by calling 1-800-206-8125.

COMPLAINT PROCESS

Complaints:

We hope our health plan serves you well. If you have a problem, talk with your PCP, or call or write Member Services. Most problems can be solved right away. If you have a problem or dispute with your care or services you can file a complaint with the plan. Problems that are not solved right away over the phone and any complaint that comes in the mail will be handled according to our complaint procedure described below.

You can call Member Services 1-833-891-9372, TTY/TDD users call, 711 if you need help filing a complaint, or following the steps of the complaint process. We can help if you have any special needs like a hearing or vision impairment, or if you need translation services.

We will not make things hard for you or take any action against you for filing a complaint.

You also have the right to contact the New York State Department of Health about your complaint at

1-800-206-8125 or write to: Complaint Unit, Bureau of Consumer Services, OHIP DHPCO 1CP-1609, New York State Department of Health, Albany, New York 12237

You may also contact your local Department of Social Services with your complaint at any time. You may call the New York State Department of Financial Services at (1-800-342-3736) if your complaint involves a billing problem.

How to File a Complaint with Our Plan:

You can file a complaint, or you can have someone else, like a family member, friend, doctor or lawyer, file the

complaint for you. You and that person will need to sign and date a statement saying you want that person to represent you.

To file by phone, call Member Services at1-833-891-9372, TTY/TDD users call, 711, Monday – Friday from 8 a.m. to 8 p.m. If you call us after hours, leave a message. We will call you back the next workday. If we need more information to make a decision, we will tell you.

What Happens Next:

If we don't solve the problem right away over the phone or after we get your written complaint, we will send you a letter within 15 workdays. The letter will tell you:

- who is working on your complaint
- how to contact this person
- if we need more information

You can also provide information to be used reviewing your complaint in person or in writing. Call Independent Health at 1-833-891-9372, TTY/TDD users call, 711 if you are not sure what information to give us.

Your complaint will be reviewed by one or more qualified people. If your complaint involves clinical matters your case will be reviewed by one or more qualified health care professionals.

After we review your complaint:

- We will let you know our decision in 45 days of when we have all the information

we need to answer your complaint, but you will hear from us in no more than 60 days from the day we get your complaint. We will write you and will tell you the reasons for our decision.

- When a delay would risk your health, we will let you know our decision in 48 hours of when we have all the information we need to answer your complaint, but you will hear from us in no more than 7 days from the day we get your complaint. We will call you with our decision or try to reach you to tell you. You will get a letter to follow up our communication in 3 workdays.
- You will be told how to appeal our decision if you are not satisfied, and we will include any forms you may need.
- If we are unable to make a decision about your Complaint because we don't have enough information, we will send a letter and let you know.

Complaint Appeals:

If you disagree with a decision we made about your complaint, you can file a **complaint appeal** with the plan.

How to make a complaint appeal:

- If you are not satisfied with what we decide, you have at least 60 workdays after hearing from us to file a complaint appeal.
- You can do this yourself or ask someone you trust to file the complaint appeal for you
- The complaint appeal must be made in writing. If you make a complaint appeal by phone it must be followed up in writing. After your call, we will send you a form which is a summary of your phone appeal. If you agree with our summary, you must sign and return the form to us. You can make any needed changes before sending the form back to us.

What happens after we get your complaint appeal?

After we get your complaint appeal we will send you a letter within 15 workdays. The letter will tell you:

- who is working on your complaint appeal
- how to contact this person
- if we need more information

Your complaint appeal will be reviewed by one or more qualified people at a higher level than those who made the first decision about your complaint. If your complaint appeal involves clinical matters your case will be reviewed by one or more qualified health professionals, with at least one clinical peer reviewer, that were not involved in making the first decision about your complaint.

If we have all the information we need you will know our decision in 30 workdays. If a delay would risk your health you will get our decision in 2 workdays of when we have all the information we need to decide the appeal. You will be given the reasons for our decision and our clinical rationale if it applies. If you are still not satisfied, you or someone on your behalf can file a complaint at any time with the New York State Department of Health at 1-800-206-8125

MEMBER RIGHTS AND RESPONSIBILITIES

YOUR RIGHTS

As a member of Independent Health, you have a right to:

- Be cared for with respect, without regard for health status, sex, race, color, religion, national origin, age, marital status, or sexual orientation.
- Be told where, when, and how to get the services you need from MediSource.
- Be told by your PCP what is wrong, what can be done for you, and what will likely be the result in language you understand.
- Get a second opinion about your care.
- Give your OK to any treatment or plan for your care after that plan has been fully explained to you.
- Refuse care and be told what you may risk if you do.
- Get a copy of your medical record and talk about it with your PCP, and to ask, if needed, that your medical record be amended or corrected.
- Be sure that your medical record is private and will not be shared with anyone except as required by law, contract, or with your approval.
- Use the Independent Health complaint system to settle any complaints, or you can complain to the New York State Department of Health or the local Department of Social Services any time you feel you were not fairly treated.
- Use the State Fair Hearing system.
- Appoint someone (relative, friend, lawyer, etc.) to speak for you if you are unable to speak for yourself about your care and treatment.
- Receive considerate and respectful care in a clean and safe environment free of unnecessary restraints.

YOUR RESPONSIBILITIES

As a member of Independent Health's MediSource plan, you agree to:

- Work with your PCP to guard and improve your health.
- Find out how your health care system works.
- Listen to your PCP's advice and ask questions when you are in doubt.

- Call or go back to your PCP if you do not get better or ask for a second opinion.
- Treat health care staff with the respect you expect yourself.
- Tell us if you have problems with any health care staff. Call Member Services.
- Keep your appointments. If you must cancel, call your PCP as soon as you can.
- Use the emergency room only for real emergencies.
- Call your PCP when you need medical care, even if it is after hours.

ADVANCE DIRECTIVES

There may come a time when you can't decide about your own health care. By planning in advance, you can arrange now for your wishes to be carried out. First, let family, friends and your doctor know what kinds of treatment you do or don't want. Second, you can appoint an adult you trust to make decisions for you. Be sure to talk with your PCP, your family or others close to you so they will know what you want. Third, it is best if you put your thoughts in writing. The documents listed below can help. You do not have to use a lawyer, but you may wish to speak with one about this. You can change your mind and these documents at any time. We can help you understand or get these documents. They do not change your right to quality health care benefits. The only purpose is to let others know what you want if you can't speak for yourself.

HEALTHCARE PROXY

With this document, you name another adult that you trust (usually a friend or family member) to decide about medical care for you if you are not able to do so. If you do this, you should talk with the person, so they know what you want.

CPR AND DNR

You have the right to decide if you want any special or emergency treatment to restart your heart or lungs if your breathing or circulation stops. If you do not want special treatment, including cardiopulmonary resuscitation (CPR), you should make your wishes known in writing. Your PCP will provide a Do Not Resuscitate (DNR) order for your medical records. You can also get a DNR form to carry with you and/or a bracelet to wear that will let any emergency medical provider know about your wishes.

ORGAN DONOR CARD

This wallet sized card says that you are willing to donate parts of your body to help others when you die. Also, check the back of your driver's license to let others know if and how you want to donate your organs.

IMPORTANT PHONE NUMBERS

Your PCP_____

Your Local Pharmacy _____

Your Nearest Emergency Room _____

Independent Health Member Services …… (716)631-8701 or 1-833-891-9372

Carelon Behavioral Health Member Services ……1-855-481-7083

-Call this number for help with mental health or substance abuse concerns.

OTHER RESOURCES

Americans with Disabilities Act (ADA) Information Line …… 1-800-514-0301

TTY …….. 1-800-514-0383

Child Health Plus – Free or low cost health insurance for children …… 1-855-693-6765

Erie County Social Services

HIV Uninsured Care Programs…….. 1-800-542-AIDS (2437)

TTY…… Relay, then 1-518-459-0121

Liberty Dental…… 1-877-550-4283

NYS HIV/AIDS Hotline …….. 1-800-541-AIDS (2437)

Spanish…….. 1-800-233-SIDA (7432)

TTY ……. 1-800-369-AIDS (2437)

New York City HIV/AIDS Hotline (English and Spanish) …… 1-800-TALK-HIV (8255-448)

New York State Department of Health (Complaints)…… 1-800-206-8125

Website…… www.health.ny.gov

New York Medicaid Choice…… 1-800-505-5678

NYS Domestic Violence Hotline…….. 1-800-942-6906

Spanish…….. 1-800-942-6908

Hearing Impaired…….. 1-800-810-7444

NYS Office of Alcoholism and Substance Abuse Services (OASAS)

Consumer Complaint Line…….. 518-547-2021

Website…….. www.oasas.ny.gov

NYS Office of Mental Health (OMH) Customer Relations…… 1-800-597-8481

Website…… www.omh.ny.gov

Office of Addiction Services and Supports

Addiction Professional Complaints…… 1-800-482-9564

Program Complaints…..…….. 1-800-553-579

Ombudsman Program……. 1-888-614-5400

Email…….…… ombuds@oasas.ny.gov

Independent Consumer Advocacy Network (ICAN) …... 1-844-614-8800 (TTY Relay Service: 711)

Email…….……. ican@cssny.org

Website…….…… www.icannys.org

PartNer Assistance Program…….…… 1-800-541-AIDS (2437)

In New York City (CNAP)…….…… 1-(212) 693-1419

Social Security Administration…….…… 1-(800) -772-1213

Independent Health
Dedicated to Making a Difference

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